

HOME HEALTH / PRIOR AUTHORIZATION REQUEST**FAX 833-853-8549 or 833-853-8550****PHONE (559) 228-2905****" Incomplete forms will be
returned for information "****"Form to be completed in Full"****Level of Function/Current Functional Status/Current Clinical Status/Justification for Skilled Care:****Current Functional Status (Detail) :**Home Bound ? ☐ Yes ☐ No**PATIENT INFORMATION**

Patient Name: Last First MI			Date of Birth (Mo/Day/Yr)	
I.D.#	Health Plan:	Prior Auth #s:	Gender: M F	

REQUESTING PHYSICIAN

Requesting Physician	NPI #	Tax ID#
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HOME HEALTH AGENCY / INFORMATION

Physician/Provider/Facility Requested		Address
Contact Person	Telephone	Fax

CLINICAL INFORMATION

ICD-10 Codes (required)			Diagnosis Description:	Teachable Caregiver Y or N
1	2	3	Recent Hospital Stay / Discharge:	Other:

CPT/HCPC Codes (required)				Discharge to: (circle) Out/Pt Rehab Home/w/Assist		Other Clinic Referral
1	2	3	4	Other (Describe)		

Discipline	Eval	Frequency	Pre-Auth	# of Visits	Start Date	End Date	Visits Auth.Office USE ONLY*	Comments:	Wound Status
SN									Location:
PT									Stage:
OT									Tunnel yes or no
ST									Measurements
HHA									Drainage
MSW									Current Treatment
									If >1 wd include wd sheet

Within 5 days before the actual date of service, provider MUST confirm that the member's health plan coverage is still in effect. With the exception of urgent requests, it is recommended that you do not schedule appointments prior to authorization approval. **Authorization does not guarantee payment.** Emergency services do not require prior authorization and are reviewed retrospectively for necessity. This message is intended only for the use of the individual/entity to which it is addressed and may contain confidential information. If the reader of this message is not the intended recipient, you are hereby notified that any distribution is strictly prohibited.

EFFECTIVE JUNE 2016